EDITORIALS

The Assault Upon the Professions

JUST A LITTLE MORE than a month ago the President of the United States on a trip to the West saw fit to ally himself overtly and publicly with what is apparently a growing assault upon the professions. Medicine has been an early target, but this time the legal profession was singled out along with medicine. Others may soon be added to the list. That this populist President found it advantageous or even appropriate to place the full weight of his office behind this growing attack suggests that it is not only becoming popular, but may be deeply rooted as well. In any case the assault has had a powerful assist, and may be expected to gather strength and perhaps even some greater element of fury.

If the assault is indeed deeply rooted, it is time to probe what might be the deep roots in order to understand it better. Something clearly has changed. Historically the professions, particularly those persons thought of as making up the learned professions—the clergy, military, scholars, physicians and attorneys—have been somewhat set apart and given both responsibility and authority to do whatever was necessary for the good of society in their fields of supposed competence and expertise. It was as though society recognized that these areas required special knowledge and skills and would be best handled by a segment of society that possessed that knowledge and those skills. This was generally true for the churches, military establishments, universities, and the professions of medicine and law.

But something has changed. Things are not working out as well as they did, or should. For example, in America the churches have been more protected than perhaps in any other nation. They should be thriving but do not seem to be. Our military establishment has certainly been well supported but we seem uncertain about it. We have invested more in our educational system than any other nation but seem to be getting less and less in the way of education for the investment. We have developed and generously supported the most advanced medical science in the world but as a nation we are dissatisfied with the health care our people are receiving and with its cost. And our legal system is clogged, seems unable to cope, and apparently is working more to profit lawyers than to effect a smooth running and efficient system of governance. Clearly, things are not going well in many, if not most, of the areas in which the professions have been assumed to have the knowledge and expertise. No one else knows what to do about the problems either, and it could be that what we are seeing is a national awakening to the fact that the professions have fallen far short of public expectations of their expertise in their fields; a perception by the public that they have failed in their public trust and indeed may have been taking advantage of their privileged positions to feather their own nests. If this analysis is anywhere nearly correct, then the assault on the professions is seen indeed to have very deep roots, is quite understandable and is likely to become more intense before it runs its full course.

But what is it that has changed and where is the true culprit? It is really neither the professions, as the public would like to believe, nor the public, as some professionals would like to believe. It is more likely that modern science and technologic progress, which have brought about unprecedented and as yet poorly understood complexities and interdependencies in every aspect of today's society, are to blame. Neither society nor the professions have given this point its due. It has posed, is posing and will continue to pose problems and challenges with which we are not yet equipped to deal. New attitudes, new approaches, new knowledge and new skills will be necessary.

At the moment there is a growing surge of public frustration and resentment. This is finding expression and outlet in the assault upon the professions, the obvious attempt to restrict or withdraw some of their privileges, while attempting to take over some of the responsibilities previously allocated to the professions which they have

failed to carry out. This will also have to run its course until a new frustration comes about. Paradoxically the same forces—modern science and technologic progress—which created the societal complexity and interdependence with which the professions have so far failed to cope to the public satisfaction, now demand even more specialized professional knowledge and skills to make such a complex and interdependent system work at all, let alone work smoothly. So it is quite predictable that when the present assault has expended itself, society will have to come to some sort of accommodation with a profession such as medicine and the rest of the professionals in health care. This could be sooner or later.

Medicine was the first major profession to undergo systematic public assault. The assault on the legal professions is now official. The educators may well be next, doubtless followed by others. Medicine should now be the first to develop a systematic approach to the very real professional problems that must be solved if the professions are to fulfill the public expectations of them in this new, more complex and increasingly interdependent society. The recent formal recognition by the medical profession of the need for cost containment in health care could be a good beginning.

—MSMW

Lithium Treatment

THE SPECIAL PLACE occupied by lithium among psychotropic drugs has several explanations: the pronounced therapeutic action in mania; the prophylactic action in recurrent affective disorders of the unipolar and the bipolar type—that is, the ability to attenuate or prevent recurrences; the chemical relatedness to sodium, potassium, calcium and magnesium; and the fact that elimination of this drug is determined solely by its renal clearance.

Due to the narrow therapeutic range of lithium, treatment is not particularly simple, and it may involve risk. Lithium administration therefore makes demands on the physician, on his skill and his care. Properly administered lithium treatment may, in return, radically alter the life of patients whose previous existence was dominated by frequent and severe manias or depressions or both. No conscientious psychiatrist can afford to disregard lithium treatment.[1]

In their comprehensive review in this issue Maletzky and Shore emphasize that prophylactic lithium treatment should be given for a long time, perhaps indefinitely. While agreeing with the substance of this statement, I would like to suggest that the prospect is presented to the patients in a different way. "Lifelong treatment" sounds unpleasantly like "lifelong prison," and after all our "sentences" are only statistical. Even if most patients who stop lithium suffer relapse, there are a few who do not, and one cannot predict whether an individual patient might belong to the latter category. I usually say something like the following to my patients: "You have been ill for many years, and presumably you will need treatment for many years. I suggest that you continue the treatment for a period of, for example, four to five years. Then we will take the matter up for discussion again." After such a period some patients have no wish to discontinue lithium therapy; they remember too well the torments before lithium and the bliss during lithium treatment. Other patients feel that their disease might now have come to an end. Discontinuation may therefore be tried under close supervision, in some cases with impunity, in others followed by manic or depressive relapses and resumption of lithium treatment.

Only one alternative to prophylactic lithium treatment seems in existence today: long-term administration of tricyclic antidepressants. The relative efficacies, merits and demerits of the two treatments have not yet been definitively established. At present the evidence indicates that lithium is better than antidepressants in the bipolar cases with both manias and depressions, and that lithium and antidepressants are about equally good in the unipolar cases with recurrent depressions.[2,3] Each of the two treatments has characteristic side effects, and for each there are particular zones of possible risk, the kidneys being in focus with lithium and the heart with antidepressants.

In their discussion of uncommon indications Maletzky and Shore call for controlled lithium trials in premenstrual tension, especially trials comparing lithium with a diuretic. Such trials are in fact on record. Singer and co-workers[4] compared lithium and placebo in 14 women suffering from pronounced premenstrual emotional tension. The trial failed to show any difference between the two drugs. Mattsson and von Schoultz[5] similarly treated women with lithium and placebo but